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ABSTRACT

This study attempted to assess family empowerment with participants in Access Vermont, a multilevel crisis intervention project for children with emotional disturbances and their families. The study used the Family Empowerment Scale, a scale based on two dimensions of empowerment level (comprised of family, service system, and community/political) and expression (comprised of attitudes, knowledge, and behavior). An analysis of use of the scale during interviews with 100 children or adolescents and their families produced three factors essential for empowerment: (1) self-efficacy (the primary caregiver's perception of her/his ability to obtain needed services for the child); (2) system advocacy (the caregiver's opinion on how effective she/he can be as an agent for change in the child's mental health care system); and (3) competence (the caregiver's feelings of competence as a parent). This three-factor solution explained 42 percent of the variance. The study plans to interview families again at 6 months, 1 year, and 2 years after intake to identify developmental changes in their reports of empowerment. (DB)

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Authors

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Introduction

Within the field of mental health, there is an increasing sentiment that services for families should be designed to promote empowerment. Empowerment has been conceptualized as both a temporary state of being and an ongoing process involving change within the individual. Although no single definition of empowerment has been proposed that captures both conceptualizations, a growing consensus has come to see it as a process through which individuals gain control of their lives through exerting influence over their interpersonal and social environments. Within the context of human service delivery systems, the process of empowerment is thought to occur when families are provided with opportunities to access the knowledge, skills, and resources that foster control over their lives and improve its quality (Singh et al.1995).

A current model specifically designed to describe empowerment for families who have children with serious emotional disabilities was introduced by Koren, DeChillo, and Friesen (1992). This conceptual framework proposed two dimensions for empowerment&endash;level and expression. The levels of empowerment were further defined as Family, Service System, and Community/Political. The second dimension, expression of empowerment, consists of Attitudes (what the parents feel and believe); Knowledge (what they know and have the ability to do); and Behavior (the actions of parents).

In light of this model, Koren, DeChillo, and Friesen (1992) suggested that empowerment might be a developmental process where parents' focus moves from immediate family concerns, to securing information and services they need to address their child's need, and finally to action to assist other families and address the needs of all children. In order to examine this model, they created the Family Empowerment Scale (FES) which is a measure of empowerment within families with children having serious emotional disabilities. Initially tested with a sample of 440

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parents, factor analysis of the FES results supported their empowerment model. To further test this conceptual framework, Singh, Curtis, Ellis, Nicholson, Villani, and Weschler conducted a study and factor analysis resulting in a factor structure similar to the FES (1995).

The FES was selected as a measure of family empowerment for the evaluation of the Access Vermont Project, a multilevel crisis intervention jointly funded by a Community Mental Health Services grant and Vermont's Family Preservation Initiative. The FES, however, was previously tested with populations whose demographics were quite different from those of families served by the Family Preservation Initiative; the current study population was poorer, comprised of more single parents, and fewer parents who participated in support groups. This summary describes assessment of the FES for use with a population more typical of crisis services-oriented family preservation programs, and includes comparison of our evaluation's factor results to the factor structures and conceptual framework derived by Koren, DeChillo, and Friesen (1992).

Method

Subjects

Evaluation participants included the primary caregivers of the first 100 eligible children and adolescents to complete the intake procedures during the evaluation period of the Access Vermont Project. To be eligible for inclusion in the evaluation, the child or adolescent had to be referred for crisis services, and determined to require a treatment team and services from two or more community agencies.

As stated before, the demographics of these families differed from those participating in previous studies utilizing the FES. For example, in the Koren et al. (1992) study, 21% of the families had annual incomes over $50,000 and only 14% earned less that $10,000 a year. Similarly, in Singh et al. (1995), 19% of families had incomes over $50,000, with 17% reporting incomes of $10,000 or less. In contrast, 86% of participants in this study reported annual incomes of less that $25,000; no families reported incomes of over $50, 000. Consequently, these families were more likely to turn to the public service system for help rather than private therapists. Additionally, in both Koren and Singh, many families reported that they were members of support groups or organizations for families with children with serious emotional disabilities. The families in the Access Vermont sample came to the program in crisis, and none reported participating in a support group prior to receiving these services.

The previous studies had a male population of over 70%, whereas males in the current study represent 49% of the sample. Another significant difference is in the percentage of children living in single parent homes. In Koren, et al. (1992), only 28% of the children lived in single parent

(1992), only 28% of the children lived in single parent families; in our study, the percentage was 43%. The strongest similarity between our population and those participating in previous studies was in race; over 75% of the subjects of all three studies discussed here were Caucasian.

Clinically, we found that over 50% of the children participating in the evaluation of the Family Preservation Initiative scored in the clinical range for aggressive and delinquent behaviors. Further, 43% of the children exhibited attention problems and 36% had problems related to thought disorders.

After receiving informed consent from the participants, demographic information, a Child Behavior Checklist (Achenbach & Edelbrock, 1991), and other measures were collected by the intake worker from the child or adolescent's primary caregiver. Within two weeks of the intake an evaluation team member telephoned the primary caregiver and collected information which included the FES and Family Satisfaction Questionnaire.

The FES consists of 34 items rated on a 5-point Likert-type scale from 1 = not true at all to 5 = very true, designed to measure two dimensions of a family's empowerment, empowerment related to various system levels and the manner in which a family expresses empowerment.

Results and Discussion

Though the demographic characteristics of our population were very different from the previous populations examined (Koren, DeChillo, & Friesen, 1992; Singh et al., 1995), the factors derived were very similar; three factors were derived which were almost identical to the four factors derived by Singh et al. (1995; see Table 1). The major difference was that the present solution has three factors while their solution had four factors, and the items in the factor they labeled knowledge were distributed over the self-efficacy, system advocacy, and competence factors for our results. Since only one item (i.e., other than those contained in the knowledge factor) moved to another factor, we used the same factor labels as Singh et al. (1995). Factor 1, self-efficacy, reflects the primary caregiver's perception of her/his ability to obtain needed services from the children's mental health system for her/his child. Factor 2, system advocacy, represents the primary caregiver's opinion on how effectively she/he can be an agent for change in the children's mental health system, and Factor 3, Competence, refers to the primary caregiver's feelings of competence as a parent. The items that moved from the knowledge factor seem to have moved to related factors (e.g., the items that relate to knowledge about system advocacy seem to have moved to the system advocacy factor).

Based on our results, the three factor solution was the most suitable, because it was most conceptually meaningful and the statistical properties were sound. The solution explained

the statistical properties were sound. The solution explained 42% of the total variance and the alpha coefficients for the factors indicate substantial internal consistency. However, the Pearson product-moment correlations among the three factors are moderately high with all the correlations being significant at the $p < .001$ level. This moderately high correlation of all the derived factors indicates that the factors are not independent (see Figure 1).

The FES has been characterized as being a useful tool for longitudinally evaluating programs intended to assist family development related to the acquisition of knowledge, skills, services, and resources from the mental health system for children (Singh et al., 1995). We view this assertion very cautiously for two of the derived factors. An examination of Figure 2 demonstrates that the self-efficacy and competence factors are highly skewed to the upper end of the scale for this baseline measure. This indicates for our evaluation that it will be extremely difficult to measure increases in these dimensions of empowerment should they occur; also, a regression to the mean may even be expected. The system advocacy factor, however, is more evenly distributed, and it may be much more useful for measuring change over time.

Finally, we examined the relationship of perceived family empowerment to various demographic, behavioral, satisfaction, and risk variables (see Figure 3). Significant differences were found between the highest scoring and lowest scoring primary caregivers on the FES for three variables. Belief in the proposition that the family and child will be unconditionally supported in services and satisfaction with services were related to higher perceived self-efficacy and ability to advocate for improved children's mental health services. High levels of perceived child behavior problems were highly associated with feelings of lack of competence in child rearing. If we assume that these associated variables are situational and subject to change in either a positive or negative direction, then it is also possible that the aspects of family empowerment measured by the FES are also situational and not developmental. We will be examining this possibility as we track this evaluation group over the next two years.

The FES, as with all the measures described in this study, measure the primary caregiver's perspective. There have been no independent observations made. However, in discussions with therapists who provide direct services, they have noted that their impressions of the empowerment of the primary caregiver, especially as it relates to competence as a parent, may be very different from the perspective of the primary caregiver. This is an indication that independent observation of primary caregivers will be necessary to measure their levels of empowerment and changes in actual behavior.

The data presented here is from the interviews that were completed within two weeks after intake and are based on only the first 100 families evaluated. Therefore, the results

are preliminary and the data will be reanalyzed when there is a larger sample to draw from which will provide a more stable factor solution. These families will be interviewed again at 6 months, one year, and two years from the time of intake to determine if they are experiencing any developmental changes in their reports of empowerment.

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